An alternative method of employing a social worker in general practice

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SUMMARY. This is an account of a scheme set up in 1977 under which a group practice employs a qualified social worker. She is employed for 10 hours a week as one of the practice's ancillary staff, so that 70 per cent of her salary is reimbursed by the Family Practitioner Committee. Her only link with the local social services department is an informal one arising out of her having previously worked in the department. She is not connected with any of the voluntary agencies which occasionally make counsellors available to general practitioners.

The advantages of the scheme include an exclusive commitment by the social worker to the practice team, rather than to an area social services team, and the greater acceptability, to both patients and doctors, of social work help by having it available on the premises. These advantages outweigh the disadvantages of some professional isolation and the lack of immediately available resources. In an economic climate which makes the chances of social workers being regularly placed in general practice even more remote than they have been hitherto, this scheme provides a possible alternative.

Introduction

DESPITE the evidence that there is a place for a social worker in the primary health care team, and despite the growing body of knowledge about how best to operate attachment schemes (Corney, 1980), there is not yet any statutory provision for social workers to be attached to general practice. There are several reasons for this. One of them, inevitably, is financial: at a time when social services departments are already having difficulty in meeting existing commitments, their limited resources are unlikely to stretch to an additional responsibility. Another reason is lack of pressure from doctors themselves: it is generally acknowledged that the relationship between the medical and social work professions has been poor and that a certain amount of distrust exists between them. Brooks (1977) argues that this poor relationship stems partly from different standards of professional training—not all practising social workers are fully trained—and partly from social workers being accountable to a social services department while general practitioners have clinical autonomy. Neither profession is likely to change its attitudes to the other or have its doubts dispelled unless they have the opportunity to work together and to experience the benefits of an attachment scheme.

In the absence of an existing local authority attachment scheme in the area, and in the knowledge that it was unlikely that such a scheme would be created, a group practice in Bath set up an independent scheme.

The Bath project

The project began in September 1977. I had been working as a basic grade social worker in the local authority social services department until June 1976, and expressed an interest in the principle of providing a social work service within the primary health care team. The group practice of four doctors had previously had a monthly visit of half an hour from a member of the social services department to discuss referral problems. His role was primarily educative and friendly, helping the doctors make better use of the social services department and following up any particular blocks in communication. This was found to be a very useful service and it was missed greatly by the doctors when it was discontinued due to pressure of work within the social services department. The doctors were therefore enthusiastic about finding a way of incorporating a part-time social worker with social services experience into the practice team. During some preliminary meetings before the project was launched, both the doctors and I discussed our expectations, so that by the time the first referrals were made all of us had a realistic idea of the possible outcome.

Paying the social worker posed the greatest initial problem: the scheme was too small to merit a research

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grant, nor was there at the time any obvious agency to provide such a grant. However, we discovered that it was possible to employ a social worker as part of the doctors' quota of ancillary staff. The Family Practitioner Committee could reimburse 70 per cent of her salary under Section 52.5(a) of NHS General Medical Services, Statement of Fees and Allowances (DHSS and the Welsh Office) because she was involved in the 'treatment' of patients. 'Treatment' is deemed to mean "such medical attention as is normally provided as part of general medical services and which it is appropriate for a general medical practitioner to delegate to a suitably trained ancillary worker". Most general practitioners accept that counselling on emotional or social matters is part of the service they provide, and in this case the doctors considered that a social worker was a suitably trained ancillary worker to whom they could delegate much of their counselling work.

As I was not employed by the local authority, I had no statutory powers or responsibilities. It was therefore an advantage to have worked in the area social services department in the past so that I was familiar with local resources and with most of the social workers to whom I could refer cases when necessary and on whom I could call for advice. I had also had experience as a medical social worker and so was to some extent familiar with the health service and with the medical profession's attitudes and methods of working.

The practice

The practice has four partners, three men and one part-time woman. There is usually a trainee working with one of the doctors. There are 10,200 patients on their combined NHS list. The rest of the team consists of a full-time practice manager, a medical secretary, three receptionists, a district midwife, two part-time nurses, two district nurses, two health visitors and a nurse running a hypertension clinic. The surgery is in a residential road on the edge of a fairly densely populated older part of the city where some families have lived for generations. The practice draws patients from a wide area but about three quarters live within a mile of the surgery. The social class of the patients is similar to that of Bath as a whole.

Working methods

At the outset, I agreed to see any patients whom the doctors, district nurses or health visitors thought likely to benefit from social work help. This arrangement allowed me to establish which problems arose most frequently and which problems the practice team felt were most appropriately handled by a social worker. Patients were usually told by their doctor about the presence of a social worker in the surgery and were encouraged to make an appointment to come to the surgery to see me during one of my three sessions. Occasionally it was easier for the patient to be seen at home, particularly if he or she was elderly or infirm. It was made clear that the patient should return to the doctor with any medical problems, such as the medical treatment of depression.

A referral card was devised which had several purposes. Firstly, it gave me the relevant information without necessarily having to read right through the patient's medical notes. Secondly, it ensured that the doctor had given some thought to the referral and had clarified in his or her own mind what exactly it was hoped the social worker might do. Thirdly, it acted as a long-term method of communication. Once the patient had had an initial interview with me and a decision had been made regarding future contact, I made a note on the card of my initial assessment and of any plans to which the patient and I might have agreed. The card was then refiled in the patient's medical notes so that the doctor had some idea of the extent and direction of my involvement. In addition to the referral card system, I kept my own, more detailed records for personal use. On an informal level, communication between all members of the team could take place freely over coffee, which was available every morning in the surgery's common room. I tried to be present once a week at this time.

Development

The original plan for me to accept all referrals was gradually refined as I became more skilful at assessing those problems which might be more appropriately handled elsewhere. It was found that there could otherwise be considerable duplication of effort. For example, the practice had several problem families on its list who were usually well known to the social services department and other agencies. Originally I added these families to my case-load because it seemed a good idea to have a social work co-ordinator based with the family's doctor. However, it soon became apparent that I had neither the time, the resources nor the statutory powers to take the action occasionally required for these families.

As I became more familiar with the rest of the practice team and my method of working and personal interests became better known, the types of referral began to change. An increasing number of people with difficulties in their relationships, whether with a spouse, cohabitee, parents or child, were referred. Some of the people had considered seeking help from other counselling services, such as Marriage Guidance, before opting for me as the practice social worker, but the majority had consulted their doctor probably with the expectation of being given some medication and a listening ear. These patients therefore relied on the initiative of their doctor in being referred to a social worker.

To balance the increase in relationship problems, there was a gradual decline in the number of referrals

relating to people with chronic, intractable problems. To begin with the doctors may have hoped that someone from a different discipline might be able to effect some change for these patients, but it soon became apparent that I was no more skilled than they were in that direction and that it was better for me to concentrate on those difficulties which presented as acute and which we therefore hoped were more capable of being changed.

As well as general changes in the type of referral made during the project, there were developments in the way the individual doctors used me. At the beginning of the project two doctors provided the bulk of the work, but as time went on the referrals became more evenly distributed. Nevertheless the distribution continued to reflect the attitude of the doctors to their patients' emotional or social problems.

Management and support

Most counselling agencies make some provision for supporting their employees. This provision may take different forms in different agencies, whether through supervision by another, more experienced person or through group meetings among peers. I was aware of my professional isolation and the consequent feeling of not belonging to any identifiable group, and of being cut off from any informal discussions of new trends in social work practice or new legislation which might affect it. I therefore enlisted the help of a registrar in psychiatry with whom I had discussions at roughly three-weekly intervals. These discussions proved very useful both in individual cases and in more general issues related to counselling. When the psychiatrist left the area, I joined an existing hospital-based discussion group of people all involved in counselling or psychotherapy. This group met weekly over lunch and usually took the form of one of its members presenting a case. It had an advantage over the individual meetings with the psychiatrist in that more than one opinion or idea would be voiced, which was more stimulating, but eventually I felt that I was spending a disproportionate amount of time each week in discussing my own or other people's patients rather than actually seeing the patients themselves. The problem of management and support therefore remained unresolved.

Range of work

The range of work which I undertook was remarkably varied and interesting, given the constraints of very short working hours and lack of statutory authority. Any attempt to categorize social problems almost invariably runs into difficulties because such problems tend to be interrelated. Thus a person experiencing marital difficulties may also have housing or financial problems. An additional difficulty with the Bath project as far as measuring the range of work is concerned has been its small size. The statistical significance of any attempt to classify or measure the type of work I tackled or the success of that work remains dubious. Nevertheless, I made an attempt to keep some sort of record during the nine months' period June 1979–February 1980 (Table 1). During this period slightly fewer than half of the patients referred to me were experiencing difficulties in their relationships and so required mainly counselling help (Table 2). The remaining patients could be more or less equally divided between the three categories of personal crisis (bereavement, serious illness, sudden breakdown of home life), psychological disturbances and practical difficulties related to housing, finance or work.

Table 1. Type of problem.

Problem group	Number
1. Relationship	17
2. Personal crisis	6
3. Psychological difficulties	8
4. Housing/financial/work	9
Total	40

Table 2. Type of help offered by social worker.

Treatment group	Number
1. Exploratory	8
2. Practical	9
3. Counselling	23
Total	40

In the nine months 37 of my clients were females and 12 were males. At any one time I carried a case-load of about six patients. The age range (Table 3) shows that three quarters of those seen were under 45 years of age. The six patients in the over 65 group all had personal crises or practical difficulties rather than relationship problems or psychological difficulties. The 40 patients between them accounted for 109 interviews, of which 26 took place at home.

Discussion

This project began as a loosely defined experiment in using a part-time social worker employed by general practitioners to provide an additional service to the patients of a group practice. Inevitably the outcome of the experiment rested heavily on the past experience and preferred method of working of that social worker as well as on the expectation of the doctors. In this case I found myself increasingly involved in short-term intervention with patients who were often experiencing difficulties in their relationships. This is as much a reflection on my own interest as it is on the type of problem which was referred by the doctors. A less limited experiment would doubtless have produced a more balanced case-

Table 3. Age range of patients.

Age	Number
Under 25	8
25-34	9
35-44	13
45-54	4
55-64	0
Over 64	6
Total	40

load of practical problems, long-term support as well as short-term case-work, although problems requiring the statutory intervention of a social services department would still have been excluded.

There were a number of benefits arising from the project, some of which appear to be common to all attachment or liaison schemes and others which arose from the relative independence of the practice social worker in this particular experiment. No attempt was made to measure the success of the project from the subjective point of view of the patients themselves, although there were sufficient positive comments from them for both the doctors and myself to feel that it was a worthwhile venture. Apart from any direct benefit which a patient may claim to have acquired by seeing a social worker, there was considerable indirect benefit for both myself and the doctors in terms of teaching and learning. I discovered some of the constraints and difficulties which a general practitioner faces each day, learned to adapt my social work skills to fit in with this more disciplined, clinical approach to problems and, without sacrificing standards of care, I became better able to select patients whose problems were likely to benefit from my intervention. The doctors became better acquainted with a social work approach to problems. This had the effect of removing some of the mystique of social work practice—a well-known block to good communication between the two professions. I was also able to use my previous knowledge of the social services department and other agencies such as the housing department to help the doctors make more effective use of them.

Another advantage of the project from both the doctors' and my point of view was my freedom from statutory responsibilities and independence from the local authority. It was easier for some patients to accept help knowing that I was employed as one of the practice team. On the few occasions when the resources or statutory powers of the social services department were required, the department was always most helpful.

The main drawback of the project from my point of view has been that 10 hours a week was too little in that there was much potential work which I did not have time to take on. Another drawback—commonly felt by independent workers—was the feeling of professional isolation.

A scheme such as this one has considerable potential. Any developments, such as more collaboration with the local social services department, would require longer hours and more contact with other social workers. Another development could be a greater involvement by the practice social worker in teaching general practitioner trainees and social work students.

My conclusion is that there is a place for a regular social work service in general practice. Further, while it is an advantage for the social worker to have experience of a social services department, and to have some knowledge of other local agencies, it is not necessary for him or her to be employed by the local authority.

References

Brooks, D. (1977). Social workers have not helped in care in general practice. *Update,* **14,** 1395-1398.

Corney, R. H. (1980). Factors affecting the operation and success of social work attachment schemes to general practice. *Journal of the Royal College of General Practitioners,* **30,** 149-157.

Department of Health and Social Security and the Welsh Office. *National Health Service General Medical Services. Statement of Fees and Allowances payable to General Medical Practitioners in England and Wales.* London: HMSO.

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Hand washing in intensive care units

Hand washing is considered the single most important procedure in preventing nosocomial infections, and has been recommended after contact with every patient. The authors observed all patients in two ICUs for a total of 60 hours. They noted how many personnel washed their hands after working with patients, and found that hand washing occurred after only 41 per cent of the contacts. The authors found that basic concepts of infection control in the ICUs were frequently ignored, particularly by doctors, who washed significantly less often than did nurses, who themselves also washed less often than physiotherapists.

Even the limited contact that occurs with a patient when taking the pulse, blood pressure or oral temperature, or just touching a patient's hand, can result in transfer of organisms that can be recovered up to two-and-a-half hours later.

Source: Albert, R. K. & Condie, F. (1981). Hand washing patterns in medical intensive-care units. *New England Journal of Medicine,* **304,** 1465-1466.